ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY

ARISING FROM THE USE OF ASBESTOS IN ONTARIO

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180 Dundas Street
Toronto, Ontario
Monday,
June 21, 1982
Afternoon Session

VOLUME 42 B

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THE FURTHER PROCEEDINGS OF THIS INQUIRY RESUMED PURSUANT TO MORNING RECESS

APPEARANCES AS HERETOFORE NOTED

DR. DUPRE: May we then resume, and I welcome Dr. Peter Pelmear, the director of the occupational health branch.

You can take it, Dr. Pelmear, with your reputation for patience already established and much appreciated.

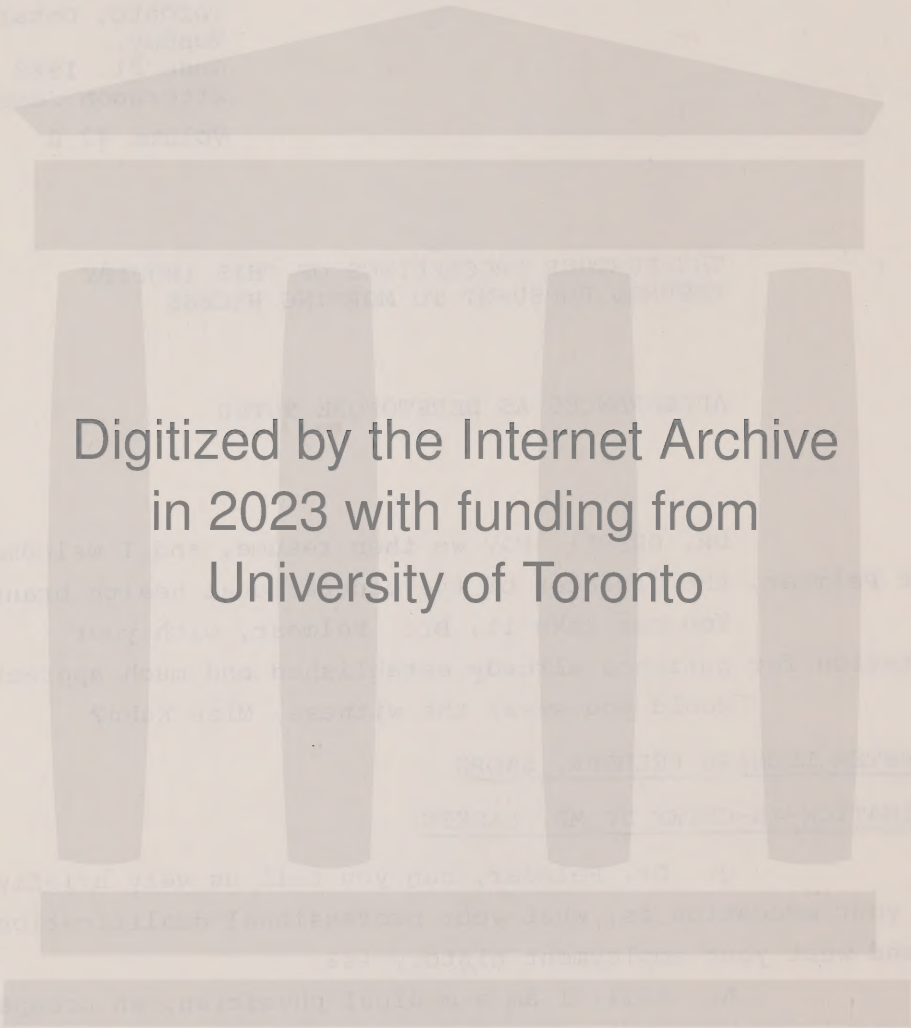
Would you swear the witness, Miss Kahn?

DR. PETER LEONARD PELMEAR, SWORN

EXAMINATION-IN-CHIEF BY MR. LASKIN

Q. Dr. Pelmear, can you tell us very briefly what your education is, what your professional qualifications are and what your employment history is?

A. Well, I am a medical physician, an occupational physician. I trained at Guys Hospital in London. I am a Doctor of Medicine, a Fellow of the faculty of occupational medicine, I have a diploma in occupational health, a diploma in public health, and I am an accredited specialist in occupational medicine



A. (cont'd.) in the United Kingdom and in Canada.

I have worked for many years in industry, in universities, and my present position is director of the occupational health branch.

Q. Of the Ministry of Labour?

A. Of the Ministry of Labour.

Q. How long have you held that position?

A. I joined the ministry on the 2nd of January, 1979, as chief physician, and took over the director of the occupational branch as well, in October or November of 1981.

Q. Did you have any employment within the Ontario government prior to 1979?

A. No, sir.

Q. You came from England?

A. Correct

Q. So you are not saddled with all of the history that our previous witnesses...

A. Recent history only.

Q. All right.

Now, I take it from looking at the organizational chart within the ministry that you have under you, then, three subbranches reporting to you?

A. That's correct. Three service chiefs.

Q. Three service chiefs. Fine. And they are the occupational health medical service, the hygiene service and the laboratory service?

A. Correct.

Q. Now, with respect to the medical service, who is the person who is reporting to you? Who is the chief of the medical service?

A. The senior medical consultant, Dr. DeBeau now is acting as part-time chief physician, as I am.

Q. Is he head of the medical service?

A. He heads up the ten physicians, the nine nurses, and I retain responsibility for the occupational chest disease section which normally would respond...would normally report directly to the chief physician.

Q. Okay. And that's the service that Dr. Vingilis headed until very recently?

A. Until November, 1979. He was...we used to have four sections, of which he was one chief. Then it was brought under my jurisdiction as the chief physician, as well.

Q. Has Dr. Vingilis now been replaced?

A. No, he has not been replaced due to restraints on recruitment.

Q. I see. So that is there anyone, then, operating the occupational chest disease service at the present time?

A. Yes. We have a radiologist, Dr. Cnan, and a physician in charge of the pulmonary function unit, Dr. Roose.

Q. Now, can I ask you what relationship, if any, your branch has with the advisory committee on occupational chest disease of the WCB?

A. No direct relationship at all. It so happens that Dr. Vingilis and Dr. Roose sit on that committee as chosen personnel, by the Workmen's Compensation Board.

Q. Do they sit on that committee, in your judgement, by virtue of the positions which they hold within the ministry, or by reason of their own personal expertise and experience?

A. By reason of their own personal expertise and experience.

Q. Now...

DR. UFFEN: John, could I just ask a quick question?

MR. LASKIN: Sure.

DR. UFFEN: Do you still host the medical examinations for the Workmen's Compensation Board chest cases?

THE WITNESS: In fact, they operate physically on our premises, and the physicians on that committee examine cases on our premises and they hold their committee meetings at the same venue.

DR. UFFEN: You inherited this situation from the time when Dr. Vingilis was both...

THE WITNESS: Chief of the section.

DR. UFFEN: Chief of the section..

THE WITNESS: Yes.

DR. UFFEN: ...and on the...

THE WITNESS: And as a member of that committee, yes.

DR. UFFEN: Are you likely to continue this arrangement?

THE WITNESS: We are likely to continue. Yes, we are going to continue that arrangement. We provide also the secretariat, but in fact the WCB are taking that over as from next month.

DR. UFFEN: Thanks.

MR. LASKIN: Q. We heard some evidence from Dr. Vingilis about surveillance of asbestos workers and so on. I take it you are familiar with that and with that operation?

THE WITNESS: A. Reasonably so, yes.

Q. The only question I really want to ask you is, to pick up the story from the time Dr. Vingilis left and ask you whether there has been, to your knowledge, any change in the ministry's surveillance program within the last couple of years?

A. Not materially. The number of companies that we visit has, obviously, reduced. In 1980, there were one hundred and ninety-one. Last year they had dropped to

A. (cont'd.) one hundred and seventy-four, and whereas approximately fourteen thousand asbestos workers were being surveyed, now the total is something like eight thousand.

Q. Is that a 1982 figure?

A. 1981/1982 report figure, yes.

Q. Has the frequency of your surveillance remained the same?

A. It has changed over the years. If I can just recap, and perhaps Dr. Vingilis told you, originally in 1952, the service was introduced, as you well know, in 1947, but in 1952, under the Silicosis Act and Regulations it was introduced then that surveillance should be at eighteen month intervals - mainly for silica-exposed workers.

Then in 1971, under the Industrial Safety Act, under the handbook requirements, this was...the requirement then said that the surveillance could be at the direction of a director and it applied to workers exposed to all health hazards, including asbestos. The frequency then was usually, I think, something like two-yearly.

The cycle for asbestos workers was in fact eighteen months until the end of 1979, when the cycle became two-yearly. But some high-risk exposed personnel were examined annually, and some indeed six-monthly, as was stated in the ministry brief which you have in your keeping.

Q. Do you have any information one way or the other as to how many of those eight thousand workers are high-exposure workers?

A. I can't give you figures. I have no idea. All I can say is, my impression is that the numbers highly-exposed now must be relatively small...because of the engineering controls which have been introduced across the industry.

Q. Does your branch, in making the assessment

Q. (cont'd.) as to whether workers have been highly exposed make that assessment on the basis of length of employment, or on cumulative exposure, or a combination thereof?

A. I think a combination of both, and the frequency of examination is really determined by the examining physician, Dr. Vingilis and his colleagues.

Q. Does your branch have exposure records on the eight thousand present asbestos-employed workers?

A. Certainly, because every examination is documented with x-rays and pulmonary function tests. Linked to that record certainly is not the environmental levels, at this moment in time.

Q. That's what I meant.

A. They are not directly linked, they are in separate records, and we are at present, at the moment, trying to introduce a computer control system so that it all will be linked. But that isn't in existence at the moment.

Q. So that...just so that I understand that...when your chest disease service goes out and examines particular asbestos workers, they will not necessarily know the cumulative exposure to asbestos that those workers have had? What they will have is a history of their lung function tests and x-rays and so on?

A. They will have their years of exposure, but they won't directly know, without further inquiry, the levels of exposure.

Q. Who maintains that record?

A. Well, that's in the occupational health branch files, which contain all the field visit reports and environmental sampling.

Q. I see. Then if I understand your evidence, there is some program afoot to computerize and link all of that

Q. (cont'd.) information up together?

A. Prospectively, it will all be on tape so that it will be very easy to recall information quickly...if it's required.

Q. Do I take it, Dr. Pelmear...just a couple more questions on the service...that from your perspective, when your branch does this service, that you perceive that the service has really been done for the employer? Is that putting it fairly?

A. Yes, it is being done for the employer. Correct.

We are providing a clinical service to the medical department of the employer. That's as we see it.

Q. I see. Does the employer pay anything for that service at the present time?

A. At the present ime, no.

Q. Is it contemplated that you will continue to provide this service in the future, for the employer?

A. It's certainly contemplated that we shall continue if the need is there.

Q. All right.

Are you trying to encourage the employer to provide his own service, if you will?

A. Yes. The Health and Safety Act implies that the employer should pay for the medical services required, and we are quite happy to encourage employers to take on this task if they've got the correct facilities and have the correct standards.

Q. I see. But I take it the Act, in suggesting that the employer ought to pay, ought to pay for your service?

A. Well, it doesn't specifically state our service, but it states that if medical examinations are required, the employer should pay.

Q. Which I take it would likely be a deterrent to a number of employers to using your services?

A. At the moment there is an encouragement to use our service because it's free...

Q. Exactly.

A. ...rather than a third party.

Q. Exactly. And if the employer then has to pay for it, I take it conversely there are some employers who are likely going to provide their own service, internally?

A. I would think so, and there are advantages because if the facilities are available internally, they are available every day and not just on our annual visitation.

Q. I guess my question would be, when you are dealing with something like asbestos, and we've heard a lot of evidence that asbestos is sometimes a difficult health hazard to examine and detect, I suppose my question is what confidence should we have that employers internally are going to be able to identify and recognize asbestos-related health problems with the same accuracy as your ministry, which obviously has an experienced and well-trained professional staff to deal with that problem?

A. Yes. I'll concede that there is a valid argument for minimizing the number of physicians involved in the screening process.

On the other hand, there are disadvantages in location and, as I say, visitations, and our concern will be that if the examining physician who reads the x-rays and interprets the pulmonary function test must be proficient, he must be a recognized chest physician or radiologist and he must be capable of interpreting the x-rays according to the ILO code. If he can do that, then he is equivalent to our staff and there is no reason why they shouldn't undertake this responsibility.

DR. UFFEN: That's a point I missed. You said equivalent to our staff. Do you have someone now on the staff who does this, or is the position vacant?

THE WITNESS: Oh, no. Dr. Vingilis, although he is retired, Dr. Roose has always read the x-rays, as has done Dr. Chan, and in fact Dr. Vingilis could well be doing some special work for us as well, but he is not presently on staff.

MR. LASKIN: Q. So that the control that the ministry would exercise in a situation where the employer was providing his own examination service would be by certification or some similar process of the x-ray technician?

THE WITNESS: A. We would expect them to engage in some sort of proficiency testing program whereby x-rays can be circulated for interpretation, and provided the physician has the appropriate qualifications and meets the provisions suggested in the control program, then we would be quite happy to recommend his services.

Q. Just coming back to your answer that this is really a service provided to the employer, as I recall Dr. Vingilis's evidence, it was that the examination results were traditionally sent to the employer or the, more properly, the employer's physician, and also to the worker's physician?

A. This has evolved over the years, and I'm led to believe that originally management received a summary of the results, and all abnormal individual reports were sent to the plant physician.

Significant disease requiring attention was sent to the family physician as well. That was the practice until about 1979, so that the management received a summary, the plant physician received the abnormal reports, and if the abnormality required attention, the family physician as well.

Then in 1979, approximately, we undertook the

A. (cont'd.) practice of reporting clear findings as well, to the plant physician, so he had reports on every case examined whether there was an abnormality or no abnormality.

We also undertook to inform the family physician by letter as well. We ran into a certain amount of difficulties because the family physicians changed, our records weren't up to date, letters went astray and it was then decided that probably the most appropriate way to do this was to send the reports to the plant physician with a sealed envelope for the family doctor, which the worker would be asked to transmit.

This ran into some difficulties as well, because the workers tended to open their envelopes.

So the present practice now is that we advise the plant physician of all the reports and place the onus on him to transmit what he thinks is appropriate, to the family physician.

But if we find abnormal findings which require attention, we take it upon ourselves to contact the family physician, as we know it, by telephone to confirm that he is in fact the family physician, and if he is, then we will send the appropriate written reports as well.

We think that that's the best we can do with the present situation.

Q. What is your practice in relation to reporting to the WCB?

A. Dr. Vingilis, over the years, instituted the practice of informing the WCB direct of any abnormality which he felt was significant, and I think that is still continuing because of his contact through that advisory committee.

Q. Just so we can clarify it, does the report go to the WCB, to Dr. Stewart or to the advisory committee?

A. I think it really goes to Dr. Stewart, who

A. (cont'd.) happens to be on the advisory committee, as you know, and so it's really not so much to the WCB, but to the clinician in the WCB who is concerned with chest disease abnormalities.

DR. UFFEN: Now, who will be sending them from now on, you or your colleague?

THE WITNESS: My colleagues in the chest disease service. Dr. Roose, presumably, will continue that practice.

DR. DUPRE: May I take it, given the precise words you are using, Dr. Pelmear, that the contacting of the WCB when your surveillance discovers an abnormality, is precisely that? It is a practice, it is not a policy of your branch or of the ministry?

THE WITNESS: That is correct.

As far as we are concerned, the WCB should only really be officially informed if there is disease which requires removal from work, and that should be instituted by the examining plant physician.

DR. DUPRE: Let me see if I understand that completely. You are saying that the policy of your branch is that the WCB should only be notified if what the surveillance has detected is a degree of impairment that is sufficient, and that at this point would mean, presumably, in the opinion of your surveying physician, to keep the individual from work? That is the policy?

THE WITNESS: That is correct. If you look at the Lead Regulation as such, we look upon it the same practice should apply. The examining physician determines that he is unfit, in which case the worker may belong to Compensation and the appropriate form should be raised.

DR. DUPRE: Okay. So that is the policy.

Your practice is that if there is some lesser

DR. DUPRE: (cont'd.) degree of abnormality noted, the WCB is notified?

THE WITNESS: The clinician in the WCB, Dr. Stewart, is interested, yes, is told on a physician-to-physician basis.

DR. DUPRE: Physician-to-physician basis, right.

THE WITNESS: So if you like, they receive early warning, but that's the only significance.

DR. DUPRE: Now meantime, the notification of the company physician, which I gather takes place whether or not an abnormality has been detected, that is a matter of policy, not of practice?

THE WITNESS: Correct.

DR. DUPRE: The notification at this point of the individual worker's family physician, is this policy or practice?

THE WITNESS: That is policy as well, that we will contact the family physician direct if there is an abnormality which is considered to be significant and requiring attention.

DR. UFFEN: Do you mind?

MR. LASKIN: No.

DR. UFFEN: Would you explain to us now what you mean by an abnormality, because I understand that now, I have it here, that if during a routine examination, periodic, one of your colleagues detects an abnormality, that triggers the following...a number of actions. But if in that individual's opinion there is no abnormality, nothing happens.

THE WITNESS: Correct.

DR. UFFEN: Then it's pretty important, I think, to understand what is an abnormality now. Is it the same as it was four years ago?

THE WITNESS: The abnormality could be an extra cervical rib or an old fracture, of no significance.

If the abnormality revealed is a pneumonia, or

THE WITNESS: what is thought to be a cancer of the lung, clearly further investigation is required to establish this, so that we are talking in terms of abnormalities which are of serious import and require followup and maybe...as opposed to an old fracture which is united.

DR. UFFEN: Would that abnormality be related in any concrete fashion to the ILO classification system?

THE WITNESS: The ILO classification system is grading the lung changes from the point of pneumonitis, and if those changes are significant, they could well advise the family practitioner as well, and they probably would do.

I think the main emphasis on the family physician is on a lung condition which requires further investigation or therapy...to make sure that it doesn't slip between the administrative process and he is not informed.

MR. LASKIN: Q. If one of your examining physicians finds what in his opinion is an abnormality requiring removal from further employment, does that physician make that recommendation either to the worker or the plant physician, or both?

THE WITNESS: A. He would make it to the plant physician, because he wouldn't be able to contact the worker directly because the x-rays are taken, the pulmonary function is taken, and it is interpreted in our chest disease section.

So the information goes to the worker via the plant physician, and if we recommended that the worker should be removed, I suppose that would happen.

The examining physician, if he got this advice from a chest clinic or anybody, would then have to contact our chest disease service and the appropriate Workmen's Compensation Board physician so that we could ensure that the recommendation was in fact valid and not spurious.

We are very concerned that people should not be

A. (cont'd.) removed from work on the basis of one x-ray interpretation, which may or may not be valid. So that our suggestion in the new regulation is that no removal should take place without third party discussions with ourselves and the WCB.

Q. I'm not...

A. The reason for this is that in the past people have been removed from the mines because of silicosis, which was thought to be silicosis and of a severity which required removal, which on subsequent investigation by the WCB and the advisory chest committee was found to be invalid, and so we had complications of people being removed from work needlessly, without the diagnosis really being verified.

We think this is a severe, very important that it should be verified not months down the line, but quickly, so that a decision, a proper decision, can be taken.

Q. Let me see if I...I just want to make sure I understand what is happening here.

The examining physician is or is not a ministry employee?

A. Strictly speaking, he is not a ministry employee. He is the plant physician, and our x-rays and pulmonary functions are clinical tests associated with that examination.

Q. I see.

A. The plant physician should be interviewing the worker, checking his history, examining him, and requiring additional clinical tests - x-rays and pulmonary function - which we take or conduct on his behalf. So that his judgement for removal should be based on his understanding of the work process, the physical state of the worker, plus the clinical findings.

Q. Could not your own branch in the medical services division come to your own judgement, based on x-rays

Q. (cont'd.) and lung function tests that a particular worker was suffering an abnormality either that, in your judgement, warranted a removal or was compensable in Compensation terms?

A. Not really. It's not good practice to base the judgement on clinical tests only. They must be taken in conjunction with your physical examination of the individual, his symptoms and signs and so on.

Q. Your branch has no role to play in that?

A. No, we haven't.

Q. You are essentially a support service to the plant physician?

A. That's right. I think if you can visualize the consultant in the ward examining his patient, he would ask the laboratory and the chest disease services to conduct tests and he receives the results of those, and in conjunction with his other findings he has to make a determination as to fitness, appropriate treatment and so on.

Q. So do your communications to the WCB, either by way of practice or policy, carry with them any recommendations as to the institution of a claim or otherwise?

A. Not so far as I am aware.

DR. UFFEN: I'm still wondering whether the system works the other way. You pointed out the possibility of a plant physician removing a person from the work and subsequently it turns out that that wasn't the correct thing to do.

THE WITNESS: Yes.

DR. UFFEN: What about the possibility of a need to be removed from the workplace, but the plant physician doesn't get the results of the x-rays and so on which he needs to make such a determination?

An x-ray is taken..

THE WITNESS: Oh, yes. Go on...an x-ray is taken... yes?

DR. UFFEN: And it is read by a competent person, one person...

THE WITNESS: Yes.

DR. UFFEN: And that person makes an error, the whole apparatus is gone at that point until either someone else examines the patient again subsequently, a new x-ray and a different interpretation.

THE WITNESS: Well, even with our present practice only one physician really reads the x-rays. If he decides the x-ray is clear, he doesn't ask for a second opinion. If he feels that there is an element of doubt, then he will ask another member of the department, 'what do you think of this finding', so that one individual inside or outside, the same applies - if he thinks it's clear, that's the end of it.

So what we are saying is, if there is a positive finding which indicates action, this positive finding must be verified by consultation.

DR. UFFEN: In previous advice we've had from experts, it has been admitted that it's not always easy to interpret an x-ray.

THE WITNESS: Yes.

DR. UFFEN: To use laymen's terms, there must be a grey area between when you see something a little bit suspicious and when you see something you are sure of.

THE WITNESS: Yes.

DR. UFFEN: Now, as I understand it these routine examinations are a year or eighteen months apart.

THE WITNESS: Yes.

DR. UFFEN: If the first examination is adjudged clear and it's incorrect, it may be eighteen months before someone

DR. UFFEN: (cont'd.) else who would have judged the first one as suspicious at least, would have a chance to see it?

THE WITNESS: Correct. But can I say that you should remember that this is a very insidious disease, which is not usually rapidly progressive, and if he has missed it, the clinician has missed something, it must be very minor to say the least, and in the further eighteen months or two years, the progression would be such that no harm would be done to the patient as a result of that delay, because of the insidious process which is involved.

I think Vingilis, better than I, could probably have advised you that in many instances minimal disease does not warrant removal, necessarily.

MR. LASKIN: Q. Is there any present policy or practice within your branch as to what is sufficient, if anything, to warrant removal in terms of an asbestos worker?

THE WITNESS: A. We have left it entirely to the judgement of the physician, and I think he takes into consideration not only the extent of the disease, but the age of the patient, the length of service that he has worked there and the number of years he is likely to further expose himself. These factors are all considered as to how he should be managed, and the worker should be appropriately advised.

Q. Of the eight thousand asbestos workers you presently have, do you have any information, Dr. Pelmear, as to how many are taking advantage of the program, or how many...

A. Oh, I think those of the eight thousand that we are seeing, and of the total number exposed I would guess the majority, but I have no figures to give you.

I think in this day and age most workers, if they have been advised to have an x-ray because of environmental exposure, few would opt out of that.

DR. DUPRE: I wonder if I could ask a quantitative question at this point. You described the medical surveillance program, as I understand it, as it has bearing on asbestos workers, as over the last...I'm not sure if it was two or three years.. having involved a change in the number of firms that declined from one ninety-one to one seventy-four, and the number of employees that declined from fourteen thousand to eight thousand?

THE WITNESS: From fourteen thousand to about eight, yes.

DR. DUPRE: Now, the number of firms I don't have any trouble with, but the number of employees, if I understand the surveillance program, is designed to keep track of individuals who have been exposed to asbestos, so by any guess of mine is a precipitous dropping. Is there anything that accounts for that?

THE WITNESS: Well, presumably the drop in the payroll...we only visit the plants, and if a worker doesn't come into the plant for his x-ray, we can't take it. Presumably, the family practitioners, if they are concerned, could be referring them to other x-ray departments.

MR. LASKIN: Q. That's what I think we are trying to get at. The eight thousand is not the ministry's estimate of the number of asbestos workers, it's the number of asbestos workers that the ministry is x-raying?

THE WITNESS: A. Correct.

DR. DUPRE: At the plant.

MR. LASKIN: At the plant.

DR. DUPRE: And what that is telling me as a layman who is trying to examine the administrative scene here, is that because your surveillance service is entirely carried out or executed on the plant floor, it automatically loses any asbestos worker who either has quit or becomes laid off or unemployed?

THE WITNESS: That's really what it amounts to, and the only plant who seriously tried to follow up the ex-employees is in fact, I'm led to believe, Johns-Manville, who have in fact encouraged all their ex-workers to attend the facilities when they are in the plant.

This does pose the problem of how you cope with ex-employees, and I think this is a difficult one because of the difficulty in maintaining knowledge of their location once they have moved the factory, and the logistics and feasibility of trying to keep check of the ex-employees.

DR. UFFEN: Is there any evidence or any possibility that an increasing number of employees are not being x-rayed because they are concerned about the amount of radiation they get exposed to by too many x-rays?

THE WITNESS: This is quite possible.

DR. UFFEN: Do you keep a record or ask them, have you been x-rayed or any other radiation...

THE WITNESS: Yes, indeed. Certainly on the initial screening they are asked if they had any x-rays before, and where. And if it's possible to locate those, then we will try and avoid duplicating x-rays.

DR. DUPRE: Let me take the case of a hypothetical employee who had been sufficiently long-term that he had been examined by your service two, three, four times. He then retires, quits or is laid off.

Can my hypothetical employee, without any particular leave from his ex-employer, show up at the plant on the day that you are there, assuming he can find out, and will he be examined if he shows up?

THE WITNESS: He could have difficulty gaining entry to the premises if he wasn't previously employed there, but if an ex-employee wished to have an x-ray, we would certainly go

THE WITNESS: (cont'd.) out of our way to afford him the opportunity - if not on the mobile circuit, at Grosvenor Street.

DR. DUPRE: In other words, if he came to Grosvenor Street...?

THE WITNESS: There would be no problem. We would x-ray him without question, and refer him to his past records which are kept.

MR. LASKIN: Q. Does he know that that service is available to him?

THE WITNESS: A. Hopefully, but I'm sure there will be instances of workers saying that they were not aware of it.

Q. Are there any plans or projects afoot within your branch to regularize or attempt to systematize some surveillance program for ex-employees?

A. Not at the present time. The nearest analogy is with the construction workers, and Dr. Vingilis may have told you that for many years now construction workers were seen annually in two locals - 95 and 58. These were an asbestos laggers union - I think the correct title is, the International Association of Heat and Frost Insulators and Asbestos Workers - and they were... have been seen since the early-sixties, I am led to believe, by our mobile units visiting the union halls. We have had, by that methodology, a response rate of something between forty and sixty percent.

So that's an ongoing process, and more recently since the end of 1981, we have extended that practice now to all construction workers, and the construction inspectorate, when they visit a project and discover that asbestos is present and workers are likely to be exposed, advise the employer under cover of a letter which is signed by me, to notify the chief

A. (cont'd.) physician of the ministry, of all the names of workers who were exposed in that construction process, with identification data, so that we can accumulate this information with a view to alerting these individuals when they have had an accumulated exposure, in various construction sites, of at least one year.

This has just been started and it remains to be seen how successful it is.

Q. How do you alert them?

A. We would have to find their address by some means, if it has not been...hopefully it will be updated and we will correspond to them through their last known address, and if that wasn't available we would have to use other ways and means.

Q. I take it at the present time in this program you are assembling information, there has been no communication...

A. Not at this moment, no.

Q. ...yet to employees?

A. Because it has only really been started in 1981, just over a year, so it's in its infancy at this stage.

Q. You rely upon the construction safety branch to advise you...

A. Advise the employer that he should notify us.

Q. Okay.

A. And in the process, he will also advise the worker, so the workers know that there is a record being kept, essentially, of their exposure, and we have no reason to believe at this moment in time that they are not getting any nonreturns.

Q. With respect to asbestos, is the construction branch being notified of all construction projects where asbestos is involved, or only those in excess of fifty thousand dollars?

A. I think you will get the true answer from the director of the inspection branch, but I suspect that it's

A. (cont'd.) predominantly only those which are notified because of their fifty thousand dollar expenditure, and there may be some small ones which are occurring at home or elsewhere, which they are not aware of.

But I think, lest you feel that that is too alarming, you must appreciate that you've got to have reasonable exposure to asbestos in order to suffer any ill effects, and the small dose sporadically is extremely unlikely to cause trouble.

DR. UFFEN: I would like to know why you come to that conclusion? I have listened to a lot of medical evidence and you are the first one that seemed to be certain.

THE WITNESS: I say extremely unlikely, sir. There is always the possibility of remote exposure causing trouble in a hypersusceptible individual.

DR. UFFEN: You said extremely unlikely, that's quite correct. But I wanted to know why you think it was extremely unlikely.

THE WITNESS: On the advice which I have been given by Dr. Vingilis and his colleagues.

DR. UFFEN: By Dr. Vingilis? Thank you.

MR. LASKIN: I don't think I have any more questions, Mr. Chairman.

DR. DUPRE: Just one last question before I ask Mr. Laskin's colleagues to proceed.

Are there any asbestos workers who are currently kept under medical surveillance by their employers so that the service which you provide is not applicable to them?

THE WITNESS: I'm going to...

DR. DUPRE: I take it from your testimony that the medical surveillance is there as a service to employers...

THE WITNESS: Yes.

DR. DUPRE: ...but that employers can provide this service themselves?

THE WITNESS: I think there may be some, but I think very few. If we are alerted to this sort of situation, we won't hesitate to send out our liaison officer to evaluate it, and we now use our physicians in the occupational health branch to go and do a field visit, to assess the circumstances and to make appropriate recommendations.

In that light, we are also sending our physicians out to plants which have been under surveillance to re-evaluate the surveillance and decide or make recommendations as to what is appropriate. It may be too much or it may be too little. But it's an ongoing review process.

DR. DUPRE: In order...Miss Jolley? Mr. McCombie? Miss Jolley.

CROSS-EXAMINATION BY MISS JOLLEY

Q. I would like to follow up that last statement you made about the low levels, and based on your discussions with Dr. Vingilis.

A. Yes.

Q. Our understanding in the discussion with Dr. Vingilis the other day was that he doesn't see cancer cases.

A. He doesn't see cancer cases?

Q. No.

A. By that he means what? Why? If they were...he only sees the x-rays that are referred to him, and some may or may not contain cancers.

Q. Right. But is he basing his statement to you on literature search, or on what...

A. I would presume on his own experience and the light of his discussions...

Q. I guess the concern is if it's on his own experience, and he admitted to us that he doesn't see cancer cases.

A. No, I'm saying in the light of his own experience plus experience of other physicians in the field. He is not isolated, or hasn't been.

Q. You've mentioned a number of times the company physician and the increasing dependence on the company physicians now for the actual...

A. Yes.

Q. ...I would like you to tell us where it is in the legislation or in the regulations that require a worker to attend a company physician.

A. The regulation refers to the examining physician...

Q. Right.

A. ...and there has been much debate as to who that examining physician should be. We have taken legal opinion within the ministry and Paul Hess has come down quite firmly that the intent of the regulation, without saying so, was that it should be...

Q. Without saying so?

A. Without...it doesn't refer to the plant physician, it refers to examining physician. The intent was that it ought to be the company, plant physician, and this is for a very good reason - that in assessing health and suitability to work, the company physician is in a privileged position, moreso than anybody else, hospital or family practitioner. He is...and he has facilities to ensure that the diagnosis is correct, within or without, and the ultimate judgement on fitness for work is dependent upon not only the clinical findings, but on the type of work to which the workers are exposed, and the family practitioner and anybody else is not in that privileged position, and in my opinion workers should not be discouraged from attending their plant phsyciain, they should definitely be encouraged to do so.

Q. You can recognize that from past experience there is some concern about plant physicians and their operation.

A. And I would say misdirected and not appropriate in this present day and age.

Q. I'm not sure.

I'm concerned about that because that policy has not been made generally...it isn't general knowledge to the trade union movement, and I wonder when that policy came through and why it wasn't communicated.

A. It was clarified in all the discussions on the Lead Regulations, which I participated in, and others...and in inquiries that we have received from unions and management outside, that although the regulation refers to 'examining physician', we take the view that that examining physician ought to be the plant physician, for the various reasons which I have stated.

DR. DUPRE: May I just try to understand that there is a distinction that I should be graspoing here?

You have expressed, as you are certainly entitled to, certain professional opinions from your experience, as to who is a more appropriate examining physician for a worker.

Now, am I correct in the following, that I should bear in mind that there is another opinion to which you have referred, which is, as I understand it, a legal opinion within the ministry that interprets the term, as I understand it, examining physician? Is that the term that is found within the regulations...

THE WITNESS: Correct.

DR. DUPRE: ...as meaning the plant physician?

THE WITNESS: No. The legal interpretation said that the intent was that it should be the plant physician. The rules don't say that it has to be. The thought process in the

THE WITNESS: (cont'd.) development of the regulation was that it should be the plant physician, but we recognize that in certain circumstances this can give rise to difficulties, and therefore we have left a loophole for an alternative - which may be used in some circumstances.

MISS JOLLEY: Q. I thought that the internal responsibility system as it exists in the new Designated Substance Regulations indicate a consultation with the health and safety joint committee over the operation of that whole medical service - the medical examinations, etc.?

THE WITNESS: A. That's right.

Q. It was our understanding in the trade union movement and the Ontario Federation of Labour, that we therefore could choose our physicians.

A. The employer has to pay, and the payor ultimately should be able to call the tune.

Q. Why?

A. Because he pays.

DR. DUPRE: For what?

THE WITNESS: For the examination.

MISS JOLLEY: Q. Why shouldn't he pay when he is the one that's causing the problem.?

DR. DUPRE: For the examination of your surveillance service?

THE WITNESS: No, for the examinations under the Regulations.

DR. DUPRE: Oh, I see. Okay.

THE WITNESS: But let me come back to you. I would hope that the health and safety committee would be satisfied with the plant physician, because if they are not satisfied with the plant physician...

MISS JOLLEY: Q. What should they do then?

A. ...he cannot function effectively, and the sooner they can make arrangements to get an appropriate physician, the better.

Q. What do they do? Do they appeal to you if they can't function with the plant physician?

A. In certain circumstances they could appeal to us and we would send our physicians out to see if we can resolve the difficulty. The ministry is...this is ultimately an industrial relations problem, and it is being dealt with daily.

Q. I have a feeling...

DR. DUPRE: If I may just be permitted a comment, I know you have tried very hard to make me understand something, Dr. Pelmear, but I'm still somehow out at sea and maybe it is the lateness of the day, but I guess what I am concerned about and I'm posing this as a question that maybe counsel, Mr. Lederer, can enlighten me on, but what I am simply concerned about is whether, in the ordinary course of business, which is a perfectly acceptable way of doing things, the Ministry of Labour sought from and received from a solicitor a legal interpretation of what the intent of a particular regulation, promulgated pursuant to the Occupational Health and Safety Act, might be?

MR. LEDERER: Perhaps I can help you with that, and Dr. Pelmear will presumably have to confirm what I say, but it so happens that I recognize the name that Dr. Pelmear has used.

The solicitor to whom he refers is an inhouse counsel. In fact, his official capacity is that he is legal director of the Ministry of Labour. As such, I should say to you, just to be entirely clear, that he is an employee of the Ministry of the Attorney-General, but is seconded into the Ministry of Labour, and it would not be unusual, as I understand it, for a ministry which is promulgating new legislation to confer with its

MR. LEDERER: (cont'd.) inhouse counsel to determine whether or not in fact the words used comply with the intent behind those words, and that I presume is what happened here.

THE WITNESS: That's correct.

MR. LEDERER: Is that of any assistance?

DR. DUPRE: Well, it assists me completely in that it confirms what I always understood would be a very standard practice.

Now, I guess the point that would become of interest to this Commission would be the...if such an interpretation was made...the basis on which it was made, because insofar as one of the matters that is properly before us is the adequacy and otherwise of the present Act and Regulations, we of course have an interest in the extent to which the current formulation is such that, of course, an individual occupying exactly the position that you described would, on the face of it, be led to the hypothetical conclusion that is there.

Of course, such a ruling, such an opinion may not exist. I'm saying, counsel, that I think we would be interested if such an opinion exists, on how the learned counsel involved got to the conclusion that he has.

MR. LEDERER: If you are asking me to make inquiries to see whether or not there is an opinion around, I will attempt to find it.

I have some concerns about it, because my suspicion is, from my own experience...well, to be blunt, my own experience in my years at the Attorney-General's Department...that what has been done here is that somebody has applied their minds to the words that were used and attempted to foresee, given the practical problems that were guessed at at the time in which it was originally

MR. LEDERER: (cont'd.) promulgated, how a court might rule if confronted with any number of potential situations. But I'm not sure that...I'm not sure if it's...

DR. UFFEN: May I ask something?

DR. DUPRE: Well, I just want counsel to finish his...

DR. UFFEN: All right.

MR. LEDERER: ...still fighting that a little bit.

DR. DUPRE: Yes.

MR. LEDERER: I'm not sure if that kind of opinion not only can't be helpful, but might be harmful in the sense that it is based upon a certain kind of knowledge at a certain time, of a certain vantage point as to the potential problems, and my sense of it is that it has a potential to harm your considerations more than help them.

I'm perfectly happy to look for it and see what's there and to make some judgement and address you on that topic once I've seen it, if that's of any assistance to you.

DR. DUPRE: Well, perhaps we might leave it at that for the time being, but you may well be prepared for some quizzing from us in terms of...

THE WITNESS: Can I just say that the question which was posed to me of who should be the examining physician is not the first one that has been asked. We have had corespondence from companies, and so on, and in order to deal with that we've had to consider it and seek out legal advice as to how we should respond, and that's the gist of the understanding as we know at the moment, that the Regulation did not specify exactly who the examining physician could be - it could be any person provided he is medically qualified, but the intent of our legislation was that it should be the plant physician, but doesn't necessarily have to be so.

THE WITNESS: (cont'd.) My view is that if it's not the plant physician, then the worker is at a serious disadvantage. And if there is lack of confidence in the work force in that physician, then something should be done to rectify that situation.

DR. UFFEN: Mr. Chairman, could I make a comment here?

DR. DUPRE: Please, Dr. Uffen.

DR. UFFEN: We've got a professional witness who is a government employee, who has under oath told us that he has been given a legal opinion from within the government service, which I believe has a significant interpretation, and I would like to see the evidence for that made available to us, if at all possible.

MR. LEDERER: Well, as I said, I will make the inquiries...

DR. DUPRE: I defer to my commissioner's expression of opinion, so you may consider that a Commission expression of opinion, counsel...

MR. LEDERER: I will phone Mr. Hess tomorrow morning before you sit and see what is available.

DR. DUPRE: Fine. Thank you.

MR. LASKIN: I'm sorry to interrupt.

MISS JOLLEY: No problem.

MR. LASKIN: Just so we are all clear, I take it, Dr. Pelmear, that your answers relate to the proposed regulation and the medical examinations required under the asbestos control program as provided for in that proposed regulation?

THE WITNESS: Well, they apply to lead and mercury, and the same philosophy extends across the board.

MR. LASKIN: Right.

MISS JOLLEY: Q. It's a concern that he who pays

MISS JOLLEY: Q. (cont'd.) the piper gets to call the tune. I mean, does he who pays the piper in terms of putting in control mechanisms also get to call the tune as to what they put in and what they don't?

THE WITNESS: A. I think this is a philosophical discussion, but I think the point was that clearly there ought to be agreement, but if there is no agreement, you choose to buy something at what price it is.

Q. What about...has the ministry looked at the options that are available in Quebec or in Sweden, for example, where there are some form of independent clinics being set up? Well, they certainly are set up in Sweden. I'm not sure how far along they are in Quebec, but the Quebec legislation allows for an independent clinic, bo be paid for by the employer, but run through the joint committee with veto powers given to the workers.

Have you ever investigated that?

A. We are aware of the legislation, the existence of it, but I think it's true to say that this is an innovation which has not yet been truly tested, and it remains to be seen as to whether it is going to be good, bad or indifferent, and I think it would be wise to observe it closely, but not to make any radical change for or against until we know more about it.

Q. It think perhaps if you go to Sweden, you could see that it has been operating there for a number of years, quite effectively.

A. Yes. And the present scheme that we have has operated very effectively in the U.K. So that we have adopted a scheme which was known to be good practice in many countries, but it doesn't mean to say it's the only scheme.

Q. I would like to just ask you a question about the medical surveillance program and the purpose or objective of the medical surveillance program.

Q. (cont'd.) It's a similar question to a question I asked Dr. Vingilis, and that is that I would like you to explain how you can ensure fitness for exposure to a carcinogen? How do you determine whether a person is fit to be exposed to a carcinogen?

THE WITNESS: A. To a carcinogen here?

Q. I assume that you believe that asbestos causes cancer?

A. Well, I think these are motherhood statements at the beginning of the medical surveillance program as objectives, and the whole purpose of any medical surveillance is to try and ensure as far as possible that the worker is physically fit for the job he has to undertake, and that he has no predisposition or susceptibility to the hazards to which he is exposed.

Q. The purpose of your regulations, therefore, are not to protect all the workers as they do in England and in Sweden and in the United States?

A. I don't think that would be a true statement. The legislation in England doesn't protect all the workers either.

Q. Well, in Sweden and the United States.

A. I very much doubt if it applies there either, because that's physically impossible.

Q. We have had testimony from both the Swedish government officials and the American, to suggest that the intent of their OSHA Acts were to protect all of the workers.

A. All in inverted commas. You know, you are asking for no risk at all, and that's just not possible.

So can I just go on, the objective is to ensure as far as possible that the worker is fit for the job he is doing.

Now, it is very difficult to say that nobody will develop cancer, but you may well find, with advancing knowledge, that certain individuals are more predisposed, and if this comes to light and it's a useful clinical test to use and to advise on,

A. (cont'd.) then it should be utilized.

But if you take something less nebulous than cancer, if you like, and take chest disease, clearly if he has got an underlying lung condition which could be aggravated by dust exposure, you would advise the worker that he shouldn't be exposed. If he is already susceptible to isocyanates or something, you would advise him that he shouldn't be exposed.

DR. UFFEN: Iso what?

THE WITNESS: Isocyanates, or any other chemical substance. If you have already...

DR. UFFEN: Isocyanates?

THE WITNESS: Correct. If you have already developed an allergy, then clearly it would be unwise that you should be further exposed.

Now, in the case of cancer this is much more difficult...at this moment in time, with present medical knowledge. But the intent is a worthwhile one.

DR. UFFEN: Does that apply to asbestos? If he has been exposed, he shouldn't be exposed any more?

THE WITNESS: Not necessarily. I think the chest physicians will tell you it depends on the amount of the exposure, and your age and so on. You could well have a small degree of asbestosis, and with only one or two years to work, and it may be considered that if that were the only job that was available to you, that you could afford to expose yourself without serious disadvantage.

But it's a judgement decision based upon the findings and the attitude of the worker as to what he wishes to do.

MISS JOLLEY: Q. I would like to pursue, since we were dealing with the past and I was criticized for only dealing in the past, I would like to deal in the present. And

Q. (cont'd.) that is, my understanding is that the Canadian Union of Public Employees were very concerned about an asbestos risk in the public library in Sudbury, Ontario, and they requested that a...last summer...and they requested that an inspection occur. In fact, an inspection did occur on September 28, 1981, which was not twelve years ago.

The report was on October 30th. The, unfortunately the workers requested the results of that test for some time, and it was only in May of 1982, that they finally received the report that said, in fact, that there was twenty-five to fifty percent chrysotile asbestos in the insulation, and that there was a health risk.

My understanding is, and I'm sorry I don't have the reports, I'll bring them tomorrow, but Dr. Gregor, in the ministry, signed this report.

Now, there was a great deal of concern expressed for the fact that those Canadian Union of Public Employees were exposed over those number of months, when in fact there was a report available and they were not given to the workers, and that's of great concern. It was raised in the legislature, and certainly your minister was very concerned.

Can you explain to us where that breakdown happened, since you are in charge of the hygiene and the laboratory?

A. The reports, as you well know, were dated and issued, and the breakdown was an administrative one in the local office in Sudbury, and unfortunately the reports did not get out to the recipient when they should have done.

Q. But you will...

A. I will temper that with the fact that you must appreciate that there are hundreds of reports going out daily, and human error is bound to occur with anything, on occasion... regrettable though it may be.

Q. Well, your minister had stronger things to say about the negligence.

May I draw your attention to another example, and that is that I would like just very briefly to discuss these exposure criteria, because this is the other way in which the ministry is approaching controlling hazardous substances in the workplace.

Is it my understanding that the ministry uses these as guidelines now?

A. They are used for discussion only. The values that we have to use as guidelines are the ACGIH values, and it so happens that the ACGIH values correspond to most of those.

Q. Right.

A. So that officially we cannot reference those because they are for discussion, but we reference the ACGIH ones, which happen to be common in many instances.

Q. What about the polychlorinated biphenyls, PCB's, which I'm sure you are familiar with?

A. I'm very familiar with that. I don't know whether you wish to discuss that in an asbestos hearing.

Q. Well, I would just like to address it because of the philosophy of a discussion you had with General Motors, where the suggested level for PCB's in this, for discussion purposes, was zero point zero zero one milligram per meter cubed, correct?

A. Yes.

Q. My understanding is that in discussions with the joint health and safety committee, with a great number of experts from General Motors at the General Motors plant in St. Catherines, Ontario, you attended a meeting with that joint health and safety committee?

A. I didn't go to the plant. I was the director

A. (cont'd.) who heard the appeal.

Q. Right. And you recommended that the level not be zero point zero zero one, but it should be zero point zero five?

A. Correct.

Q. I would like you to explain to us why you made that recommendation when it's clearly of concern in your ministry that it be lowered.

THE WITNESS: Mr. Chairman, is it right and appropriate that I should have to respond to this?

MR. LEDERER: Dr. Pelmear beats me. I hesitate to say anything, I've been striking out all day, but I really wonder whether there isn't a limit beyond which we have now passed. What we are being asked for here is a judgement that was made to a totally unrelated substance, and...

DR. UFFEN: Small conference.

DR. DUPRE: Dr. Pelmear, we are interested in having this matter pursued. It's relevance to us, I think, is fairly self-evident if you bear in mind that among the matters with which we are concerned are included the degree of discretion that, of course, is vested, and very often most properly vested, but nonetheless vested, in officials of the ministry.

So we would be interested.

THE WITNESS: All right.

The circumstances here were that the situation arose at General Motors in St. Catherines, where the ministry had to reference the number as given in their booklet for discussion only, because the ACGIH mentions five hundred and a thousand depending on the concentration of PCB's.

In fact, we referenced that number because that was the ministry guideline - although the booklet had not been published at that time for discussion. Subsequently, there was

THE WITNESS: (cont'd.) an appeal by the company concerned, in the proper manner, and they appealled to the director and the company presented evidence from their toxicologists and epidemiologists to justify that the level should remain at five hundred and one thousand.

The union representatives who were made party to the appeal argued in favor of the one, which was in fact the original NIOSH recommendation.

It was subsequently demonstrated to me that the NIOSH analysis was suspect, and that the epidemiological evidence was such as not to justify this level of one, and we therefore settled for fifty, which seemed to be very reasonable in the circumstances, to safeguard the health of workers, and also to permit the operation in that plant to continue.

DR. DUPRE: May I, Miss Jolley, please, for the sake of the record ask you to name the exact title of the booklet from which you are...?

MISS JOLLEY: Yes, I'm sorry. It's, The Exposure Criteria for Potentially Harmful Agents and Substances in Workplaces, the Ontario Ministry of Labour.

DR. DUPRE: Right. Okay.

Now, as I would take it, in the design of any kind of policy that is going to involve exposure criteria, it would certainly be part and parcel of a policy structure that would, to me, make sense that of course some numbers are going to be put out there and put up front for individuals to react to.

As I would take it, you have referred to a document which basically is meant to be that kind of a discretion or suggested type of step in the design of the policy, and as I would take it at this point, vesting some discretion in a senior official to make the kind of decision that was referred to in this one case, seems to me to be a reasonable way of trying to

DR. DUPRE: (cont'd.) ensure that if you put out a set of values for discussion purposes, they don't automatically become the norm on the spot.

Am I failing to see...in other words, I'm seeing something here, Miss Jolley, that strikes me as not unsound administrative procedure at all. Am I failing to see something in the line of questioning, that you have been trying to bring to my attention here?

MISS JOLLEY: I'm sorry I've been a little obscure. The notice in the front of it indicates that "the numerical values specified in this booklet are guidelines only", and I think that we interpreted that statement - this is the ministry also, a Ministry of Labour statement - to indicate that these were guidelines that the ministry was now following.

Our understanding of guidelines was that they were not necessarily open to that amount of discretion by the ministry officials.

THE WITNESS: As I've said, by virtue of the subtitle, 'for discussion only', we cannot reference that booklet. The only booklet that we can reference is the ACGIH, which we are in fact using.

MISS JOLLEY: Q. You did indicate though, however, that you did have an internal ministry guideline of zero...point zero zero one?

THE WITNESS: A. We did, and we had Ontario figures for carbon monoxide and many other substances, which were at variance.

Q. Right.

A. Which were included in that criteria booklet. But as it has now gone out for discussion, we are now embarrassed that we can't really reference it without any degree of authority.

Q. You mean you can't reference the thirty-five parts per million for carbon monoxide right now?

A. That's our present level, isn't it. Whereas the ACGIH is fifty-five, isn't it.

Q. Right. Fifty.

A. But strictly speaking, we should be not referencing thirty-five, because it's for discussion.

Q. I don't want to pursue this because it's not directly dealing with asbestos, but it's of concern to us where the levels of carbon monoxide is now, that...

A. The sooner we can get the discussion over and get agreement, then we've got a proper reference.

But I think...can I just enlarge...these are figures and they are all guidelines, and it isn't the end point of the situation. You judge the work situation on what you find, and this is one factor, amongst many, in which you decide whether it's safe or not safe to operate.

Q. But presumably you had background references to indicate that these levels would protect peoples' health? I mean that's the reason...

A. Not everybody's health, the majority.

Q. Right, but point zero zero one surely had some health reason for you putting it in this booklet?

A. That was the NIOSH reference criteria data, which was subsequently shown to be less sound than it was thought to be at the time.

Q. By the General Motors?

A. By General Motors and other sources.

MISS JOLLEY: I have no more questions.

DR. DUPRE: Thank you.

Mr. McCombie?

MR. McCOMBIE: I shouldn't be too long. I just want to follow up a couple of things.

CROSS-EXAMINATION BY MR. McCOMBIE

Q. Just to get back to the company doctor, plant physician, for a minute, if I understood your testimony correctly, virtually everything is funnelled through the company doctor, including indications where there is an abnormality that it is suspected should remove the worker from the workplace, is that correct?

A. That's correct, if there is a plant physician. If there is no plant physician, then we have to go to the family physician directly.

Q. Okay. But assuming that there is a plant physician and you or your group find an abnormality that suggests an urgent need to remove the worker, that would go to the company doctor. Would the worker not be notified at all?

A. He would be notified via the company doctor. The onus is on...

Q. But it would only be via the company doctor?

A. Because we are working for the medical department in the plant. We are not working directly for the worker. We have no direct responsibility to respond to the worker.

Q. Is there any mechanism for following up with the plant physician whether or not the worker is notified, and what subsequently happened with that particular worker?

A. Only if we felt that there was a condition which I said, which was significant to require therapy, we would go to the family physician. We don't make direct contact with the worker at all.

Q. And you wouldn't follow up with the plant physician as to what had happened with that particular worker?

A. Oh, I think almost certainly, where we are finding, shall we say a cancer, we are not going to sleep on it.

A. (cont'd.) Dr. Vingilis and his colleagues have gone out of their way to make sure that attention is provided.

Q. You also indicated that where there is an indication that the worker should be removed, you generally get involved in third party consultations...

A. Yes.

Q. ...and if I understood you correctly, this involved the Compensation Board at that point?

A. Yes.

Q. So who would the three parties then be?

A. The three parties would be the examining physician, the occupational chest disease service and a WCB representative, because we feel that those three parties will have to...the WCB needs to be involved because they are going to have to carry the compensation and we feel it appropriate they should be involved in this process - not to deny compensation, but to make sure that it is appropriate and applicable.

Q. So it would be the WCB, the plant physician if applicable, and someone from the branch?

A. Yes. Correct.

Q. What kind of consultation would this be? I mean, what kind of input would the WCB have at that point? Would they be...for example, would the discussion arise as to whether or not this particular problem would be compensable?

A. No, it's primarily to determine the interpretation of the x-ray findings and the pulmonary function, with input from the plant physician as to the nature of the work, the exposure, so that all facts will be taken into consideration to see whether removal from work is justified, and if it's justified, then automatically he would receive compensation.

Q. Not necessarily.

Would these people from the WCB be people from the

Q. (cont'd.) medical services section?

A. They would be Dr. Stewart or his equivalent, without question.

Q. So there would be no one from any of the others?

A. It's a clinical conference.

Q. I would like to now turn to a couple of questions I asked the previous witness, and perhaps you can enlighten us on these.

Particularly, the question of reports, consultations, again with the WCB, and it was indicated by Mr. Rajhans that the WCB would, on occasion, contact the branch to get information and whatnot, and I asked the question of him if a worker, a claimant, contacted the branch for information whether the branch would supply that worker with information.

A. The practice has been that if a claim is pending, and the WCB has got all the information and a worker or a third party is requiring that information, we have suggested that they should approach the Workmen's Compensation Board because all the information is there.

Q. How long has this been the practice?

A. As long as I can remember.

Now, if the claimant is dissatisfied, he will appeal, as you know, and all the information is open and available to him.

Q. That's only as of December of 1981. The information was not available to the worker prior to...

A. It was...well, correct me, I thought if it was an appeal he could get it anyway.

Q. No. He can now, but this was only as of December 1981, and you are indicating that this has long been the practice of the branch.

A. Well, as far as I can remember.

We have certain...that's been our sort of practice, to try and avoid third parties getting the information, in addition to the WCB, while they are considering the case.

Now, that does not rule out...

Q. So you...

A. ...third parties getting information...

Q. Sorry, if I could just interrupt. You are indicating that you would consider a worker who has a claim for an asbestos-related disease is the third party in this case?

A. Well, I'm sorry, in the sense, only a third party in the sense that it was another source asking for information in relation to an appeal...not an appeal...

Q. The previous witness indicated that the prime philosophy of the branch was to protect the health of the worker, and given that philosophy surely the worker would be the number one priority, the company doctors would come further down the line?

A. In this instance, the worker has got a claim in which is being considered. We are providing all the information which is necessary for that claim to be fully appraised, and I fail to see that there is any need for any further dissemination of documentation in relation to that matter under consideration.

Now, that does not rule out release of documentation. Under the Act, it permits the director to.. under section 34, subsection 3, to release documentation as appropriate...and this is being done in many instances, and workers in plants who say they haven't got the field visit reports, we have released them.

Q. But this wouldn't necessarily be in WCB cases?

A. All I can say is that in the WCB case which

A. (cont'd.) we know is actively under consideration, we have tended not to disseminate that information until the WCB has had an opportunity to evaluate it and make a decision on it.

Q. Would that be policy, practice, or perhaps legal interpretation?

A. Well, I think that has been practice.

Q. All right.

I guess the other question I would like to put to you, as was asked of the previous witness both by myself and Mr. Lederer...and I appreciate that as was stated when you were first introduced that you have only been there a short time, but given what you have b-en able to see, and the history you have been able to read up on and people you have talked to, I'm just wondering whether you see this Occupational Health and Safety Act as having dramatically changed the role of the ministry in health and safety? I realize that might be a bit unfair given your newness to the job, but...

A. I don't know that it has dramatically changed. It obviously has changed the role of the ministry. Certainly from my understanding, is that the occupational health branch services were routine and regular, and the philosophy of the Act is for internal responsibility, and therefore we have certainly departed from the ritual process of going back into plants and re-examining on a cyclical basis.

As Mr. Rajhans said, this is by design, to ensure that the plants do their own monitoring, which is their responsibility.

But, that does not preclude us from doing audit visits periodically, which we will do, not only to sample, but to look at the records to see what has been done, and our sampling is really to verify or confirm that the tests done by the plant are in fact appropriate and adequate.

Q. Would you feel then, in general terms, that the Act, the 1978 Act, has been a small step forward, I guess you are saying?

A. I would venture to suggest that it has been a great step forward.

Q. A great step forward, in protecting of workers' health in the workplace?

A. In getting involvement of all parties who need to be concerned with the issues, and thereby, hopefully, greater success than was enjoyed previously.

MR. McCOMBIE: Okay. I think that's all the questions I have.

DR. DUPRE: Mr. Lederer?

MR. LEDERER: I have no questions, Mr. Chairman, thank you.

DR. DUPRE: Dr. Uffen?

DR. UFFEN: I'm not sure I'm pronouncing his name correctly, but Dr. Ving...

THE WITNESS: Vingilis.

DR. UFFEN: Vingilis was here rather a long time, trying to establish whether an internal procedure was being used for a classification of x-rays. I'm not sure I know how to describe it, but it was in addition to the ILO code.

Is that still being done?

THE WITNESS: It's still being done, sir, because the WCB use that sytem, I think, because of their computer, and you quite rightly have reservations about its validity. But we are having to use it because the WCB assessments are based on that, but in parallel we are insisting that the ILO system be introduced as well.

DR. UFFEN: Now, a related question. We can ask you where do you send information and so on.

THE WITNESS: Yes.

DR. UFFEN: I'm still learning about the WCB, but it has a medical advisory panel.

THE WITNESS: Yes.

DR. UFFEN: And the ties with your branch have been quite close in the past because a member of your branch has also been on the WCB?

THE WITNESS: Yes.

DR. UFFEN: That doesn't exist at the moment, am I right?

THE WITNESS: This is the advisory panel on chest diseases.

DR. UFFEN: The advisory panel on chest diseases, to the Workmen's Compensation Board?

THE WITNESS: Correct. That's the panel that Vingilis sits on, and Dr. Roose sits on.

DR. UFFEN: And Dr. Roose is...?

THE WITNESS: Also working for me. So I have two members in the chest disease section who sit on that panel.

DR. UFFEN: Are you including Dr. Vingilis as the second of the two?

THE WITNESS: He was. He has now left, if you like, and he is no longer with us. So I've still got one... but there by virtue of his expertise, not as a ministry representative at all.

DR. DUPRE: And the same is true of Dr. Roose? He is also there as a matter of his expertise?

THE WITNESS: That's right.

DR. DUPRE: Not as a member of the...

DR. UFFEN: But the rest of my question is, does the information from that advisory medical panel to the WCB automatically come back to your branch?

THE WITNESS: Not at all.

DR. UFFEN: In other words, the practicing physician wears his physician's hat when he is over there?

THE WITNESS: Yes, that's right. It's input to the WCB, and I have no information from them at all.

DR. DUPRE: They are acting, as I understand it, as consulting physicians to Dr. Stewart?

THE WITNESS: Correct.

DR. DUPRE: And are in no way acting pursuant to any position that they hold in the classified civil service under you and your branch?

THE WITNESS: That's correct, sir.

DR. UFFEN: Now, one final little question, since I don't know all that's required in a medical examination.

THE WITNESS: Yes.

DR. UFFEN: When that advisory panel has a medical examination, my understanding is they have one, maybe two of their experts examine the patient?

THE WITNESS: Yes.

DR. UFFEN: It has in the past been done in your branch facilities?

THE WITNESS: Yes.

DR. UFFEN: Could it be done elsewhere just as easily?

THE WITNESS: It could be done elsewhere just as easily, but I think the primary function, examination facilities which we have, are really second to none, and I think they would be hard pressed to find the equivalent in any hopsital situation.

DR. UFFEN: Even the Toronto hospitals?

THE WITNESS: Yes, sir.

We have...

DR. UFFEN: Not being from Toronto, I'm quite astounded that...

THE WITNESS: Well, I think that's true. It has been built up over the years, partly by contributions from the WCB, but mainly from the Ministry of Labour, and there really is no assessment on primary function which that unit cannot do.

DR. UFFEN: I'm going to ask you now, just as an opinion, I understand that, but from the point of view of the patient, is the patient expected to understand that the professional people are operating quite distinctly, not representing the ministry, even though the examination takes place in the ministry facilities?

THE WITNESS: It is probably not clear to them, sir, because you have only now yourself grasped it, and almost certainly patients assume they are having a ministry examination because it is Ministry of Labour premises.

DR. UFFEN: Thank you.

DR. DUPRE: I just have one question at this point, Dr. Pelmear.

I appreciate the importance which you attach, both as a member of the ministry and as a professional, to the role of a company physician vis a vis medical surveillance.

THE WITNESS: Yes.

DR. DUPRE: Now, can I take it that all firms in Ontario whose employees are eligible for your medical surveillance service have company physicians?

THE WITNESS: No, sir. Not all do.

DR. DUPRE: Now for those who do not, what then happens to your, I take it, well-held opinion?

THE WITNESS: They are at a disadvantage, and the results just go to the family practitioner. But most of our surveillance in future will be covered under designated substance regulations, in which case there will have to be an examining physician for the plant - one or several - and he

THE WITNESS: (cont'd.) must be...clearly his responsibilities are there for him to see, he must be informed and where he is lacking in any respect, the physicians in my branch are available to advise him and counsel him.

DR. DUPRE: Let me see if I understand it as clearly as possible.

I can take it that one of the things that is triggered by the act of designating a substance is that there will indeed by a company physician who is an examining physician?

THE WITNESS: Yes.

DR. DUPRE: But of course the substance must be designated?

THE WITNESS: Yes.

DR. DUPRE: To the extent that there is a long lead time between the broaching of a substance for designation and the actual naming of a number...a lead time which is, in my view, entirely understandable if the process is going to work... what has not yet been triggered while we are waiting for the number is the designation of a company, or an examining physician who is a company physician?

THE WITNESS: Yes.

But all is not lost, because we can and have used section 20, and without designation, if we feel that the substance is sufficiently hazardous, we can issue a section 20 order requiring appropriate medical surveillance by an examining physician, and we have done so.

DR. DUPRE: And as I understand it, section 20 involves the action of, in the words of the legislation, the director?

THE WITNESS: Correct.

DR. DUPRE: And you qualify as a director for the purpose of section 20?

THE WITNESS: Yes, sir.

DR. DUPRE: Are you the only person who qualifies as a director for the purpose of...

THE WITNESS: No. As a matter of fact, it's any director and we have practices on the same basis as the occupational health branch functions. My branch evaluates the substance, makes the appropriate decisions, and we request the line branch directors to issue the section 20 order.

DR. DUPRE: May I ask, in terms of the substances - there aren't that many - which just under the recent process have been on their way to designation, so to speak, has section 20 been invoked in each case, so that there is in fact an examining physician who is a company physician?

THE WITNESS: The section 20 has not been in relation to any of the proposed designated substances to date.

DR. DUPRE: I see. It has not been used, then, to bring about a situation where, while you are waiting for the number, a company physician is in fact mandatory?

THE WITNESS: Not yet.

DR. DUPRE: It has not been used...

THE WITNESS: But if we thought it was appropriate and we found such a situation, we would certainly use it.

DR. DUPRE: Thank you.

Counsel, any questions?

MR. LASKIN: No. No questions, Mr. Chairman.

DR. DUPRE: Well, Dr. Pelmear, may I thank you very, very much for your patience and for staying on to this time.

May I take it, counsel, that we now rise until ten a.m. tomorrow morning?

MR. LASKIN: Ten o'clock tomorrow morning.

DR. DUPRE: Thank you, indeed.

THE WITNESS: Thank you. I appreciate finishing today, sir. Thank you very much.

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THE INQUIRY ADJOURNED

THE FOREGOING WAS PREPARED
FROM THE TAPED RECORDINGS
OF THE INQUIRY PROCEEDINGS

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